

Schertz-Cibolo-Universal City ISD Child Nutrition Department

Medical Statement Form

(To Provide Information for a School to Make an Appropriate Meal Accommodation)

PART A. Student, Parent/Guardian, and School Contact Information – To be completed by a parent/guardian or school contact person. Incomplete forms cannot be processed and will be returned.		
Student's Name:	Date of Birth:	School:
Parent/Guardian's Name:		ID #
Parent/Guardian's Email:		Cell Phone:
Please check meals student will eat: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch		Please check if student has a: <input type="checkbox"/> 504 <input type="checkbox"/> IEP
PART B. Prescribed Diet Order – This part must be completed by a State Licensed Healthcare Professional		
Check ONE: <input type="checkbox"/> Student has a Disability/Impairment <input type="checkbox"/> Student has other medical condition that does not rise to the level of a disability		
1. Describe/explain the student's Disability/Impairment or medical condition:		
2. What major life activities/major bodily functions are affected by the Disability/Impairment or medical condition?		
<input type="checkbox"/> Student has a prescribed Epi-Pen		
3. How/why does this Disability/Impairment or medical condition restrict the student's diet?		
4. Explain/describe the meal accommodation for the child's Disability/Impairment or medical condition:		
5. Type of Special Diet: <input type="checkbox"/> Student does not require a special diet <input type="checkbox"/> Student requires a special diet. Please describe: (i.e. low sodium, gluten-free, diabetic, etc.)		
6. Foods to be Omitted and Substituted: <input type="checkbox"/> Not Applicable		

Dairy (Please specify)		
<input type="checkbox"/> No Fluid Milk	<input type="checkbox"/> No Cheese	<input type="checkbox"/> No Yogurt
<input type="checkbox"/> No milk in ANY products (i.e. baked goods like bread, cookies) <input type="checkbox"/> Other:		
<input type="checkbox"/> Milk Substitute Needed. Specify Type (lactose-free, soy, etc.): _____		
Additional Information:		
Eggs (Please specify)		
<input type="checkbox"/> Whole eggs <input type="checkbox"/> Eggs in foods (i.e. baked goods like bread, cookies)		
Additional Information:		
Other Allergens: <input type="checkbox"/> Wheat <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree Nuts <input type="checkbox"/> Fish <input type="checkbox"/> Shellfish <input type="checkbox"/> Soy *		
* Soy Allergy: Research states that <i>soy lecithin</i> and <i>soy oil</i> is well tolerated by persons with soy allergy. If student avoid these ingredients, please check here <input type="checkbox"/>		
Other foods to be omitted: (please be as specific as possible)	Substitution:	
7. State Licensed Healthcare Professional Information – Must be completed by student’s health care provider. Please write clearly		
Signature	Title:	
Printed Name:	Phone:	Date:
Part C. Parent/Guardian Permission – To be completed by a parent/guardian		
I give permission for school personnel responsible for implementing my child’s prescribed diet order to discuss my child’s special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child’s school meals. I also give permission for my child’s medical authority to further clarify the prescribed diet order on this form if requested to do so by school personnel.		
Parent/Guardian’s Signature:		Date:

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